Genetics Task Force
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Overview of Genetic Information & Insurance
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This material is intended of be a brief overview of the laws, rules, and practices regarding the use of genetic information in the insurance industry. Any errors or omissions contained in this summary are those of the author.

I. Health Insurance

General rule - Genetic information cannot be used to deny, cancel or non-renew a policy or to rate a consumer.

A. Individual coverage

Issuance - Health policies are "guaranteed issue," they must be issued to applicants regardless of health status or pre-existing conditions. RCW 48.43.018. There is a caveat - after E2SSB 6067 in the 2000 legislative session, a carrier can require applicants to complete a questionnaire that serves as a health screen. The questionnaire is designed to screen out the 8% of enrollees who are the costliest to treat. RCW 48.41.060(1)(a). The questionnaire identifies conditions currently or previously under treatment. It does not ask for genetic information or family history.

Renewal or cancellation - Coverage is "guaranteed renewable." This means coverage cannot be altered, non-renewed, or cancelled based on health status, conditions, or information. RCW 48.43.038.

Exceptions – Carriers can cancel or non-renew an individual in the following situations:

(a) Nonpayment of premium;

(b) Violation of published policies of the carrier approved by the commissioner;

(c) Covered persons entitled to become eligible for medicare benefits by reason of age who fail to apply for a medicare supplement plan or medicare cost, risk, or other plan offered by the carrier pursuant to federal laws and regulations;

(d) Covered persons who fail to pay any deductible or copayment amount owed to the carrier and not the provider of health care services;

(e) Covered persons committing fraudulent acts as to the carrier;

(f) Covered persons who materially breach the health plan; or

(g) Change or implementation of federal or state laws that no longer permit the continued offering of such coverage.

Carriers can close or withdraw plans in the following situations:

(a) A carrier has zero enrollment on a product;

(b) A carrier withdraws from a service area and demonstrates to the Commissioner that the carrier's clinical, financial, or administrative capacity to serve enrollees would be exceeded;

(c) The carrier discontinues offering a particular plan and provides each covered individual with 90-day notice and option to enroll in any other individual plan currently offered by the carrier without taking the questionnaire. In discontinuing coverage and offering the optional coverage, the carrier must act uniformly without regard to any health status-related factor;

(d) A carrier discontinues offering all individual health coverage in the state and discontinues coverage under all existing individual health benefit plans. The carrier must provide the Commissioner and each covered individual with 180-day notice that it will discontinue offering all individual health coverage in the state. If

the carrier withdraws all individual coverage in the state, the carrier may not issue any individual health coverage in this state for a five-year period.

Preexisting conditions - A carrier cannot deny, exclude or limit coverage based on a pre-existing condition. The carrier can impose a waiting period of up to 9 months for a pre-existing condition "for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months prior to the effective date of the plan." RCW 48.43.012.

Rates - All persons who have individual products with the carrier are "pooled" together and the experience is rated. Rates are for all members of that pool and can be adjusted only for geographic area, family size, age, tenure discounts, and wellness activities. No one person will experience a different rate increase regardless of health status. RCWs 48.44.022 and 48.46.064

B. Group coverage

1. State Regulation

Issuance - Health policies are "guaranteed issue," they must be issued to applicants regardless of health conditions. RCW 48.43.035.

Renewal or cancellation - Coverage is "guaranteed renewable." This means coverage cannot be altered, non-renewed, or cancelled based on health status, conditions, or information. RCW 48.43.035.

Preexisting conditions - Small groups have no more than 50 eligible employees. RCW 48.43.005(24). A large group is over 50 eligible employees.

Large Group - A carrier can "impose a three-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment within three months before the effective date of coverage." RCW 48.43.025(1).

Small group - A carrier can "impose a nine-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment within six months before the effective date of coverage." RCW 48.43.025(2).

Rates - All small groups with a carrier are "pooled" together and the experience is rated. Rates are for all members of that pool and can be adjusted only for geographic area, family size, age, tenure discounts, and wellness activities. No one person will experience a different rate increase regardless of health status. RCW 48.44.023.

2. Federal Regulation/HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) includes a nondiscrimination provision regarding genetic information.

Application - The nondiscrimination portion of HIPAA applies to group coverage. A group health plan provides health coverage for a group of employees and dependents. It may be sponsored by an employer or a union and includes private employer plans, federal governmental plans, non-federal governmental plans, and church plans.

Issuance - A plan or issuer may not base eligibility on an individual's or a dependent's health status, physical or mental medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.

Genetic information includes:
- Information about genes, gene products, or inherited traits
- Carrier status
- Info. from laboratory tests that identify mutations in genes or chromosomes
- Family history
- Direct analysis of genes or chromosomes

Preexisting conditions - A preexisting condition exclusion is limited to a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period prior to enrollment. During the preexisting condition exclusion period, a plan does not have to cover or pay for treatment of a medical condition that was present prior to an individual's enrollment in the new plan or policy. (The plan or issuer must, however, pay for any unrelated covered services or conditions that arise once coverage has begun.) The enrollment date is the first day of coverage, or if there is a waiting period before coverage takes effect, the first day of the waiting period. A group health plan can apply a preexisting condition exclusion for no more than 12 months (18 months for a late enrollee) after an individual's enrollment date. Any preexisting condition exclusion must be reduced by an individual's prior creditable coverage. No preexisting condition may be applied to an individual who maintains continuous creditable coverage (without a break of 63 or more days) for 12 months (18 months for a late enrollee).

Rates - Employers may establish limits or restrictions on benefits or coverage for similarly situated individuals or a higher premium or contribution for similarly situated individuals (“similarly situated” refers to employment status, not health status or conditions). Employers may change plan benefits or covered services if proper notification is given to employees. Health factors (including genetic information) cannot be used to determine premiums; premiums may vary based on factors such as age, gender, geographic location, or family composition.

Pre-emption - HIPAA generally allows the law or regulation that provides the most protection to the consumer to prevail. For example, a state can adopt shorter pre-existing exclusion times.

II. Disability Insurance

General Rule – Insurers can underwrite based on health information and can exclude preexisting conditions. This general rule does not apply to health benefit plans offered by disability insurers that are subject to the same requirements as health insurance offered by an HCSC or HMO.

A. Individual coverage

Issuance - Insurers can underwrite based on health information. An insurer does not have to issue a policy.

Renewal or cancellation - Plans may be guaranteed renewable or noncancellable. If they are not, they must clearly state the conditions for renewing or cancelling. Industry practice is that health information is not used to cancel or nonrenew after issuance.

Rates - Similar policy forms should be grouped for rate-making because they are expected to have substantially similar insuring, risk and exposure factors and expense elements. Grouping improves statistical reliability and improves the likelihood of premium adequacy without introducing elements of discrimination. It is unfair to withdraw a form from its assigned grouping by reason only of the deteriorating health of the insured persons. WAC 284-60-040. Benefits are reasonable in relation to the premiums if the overall loss ratio is at least sixty percent. WAC 284-60-050.

Preexisting conditions - The definition in WAC 284-50-315 is the "existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a five year period prior to coverage of the insured person." Insurers can exclude pre-existing conditions.

Insurers can also exclude specific diseases or conditions or utilize a probationary or waiting period. The probationary or waiting period cannot exceed six months for "specified diseases or conditions and losses resulting therefrom for hernia, disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis." WAC 284-50-320.

B. Group coverage

Issuance - Insurers can ask for health information and underwrite based on the information.

Renewal or cancellation - Plans may be guaranteed renewable or noncancellable. If they are not, they must clearly state the conditions for renewing or cancelling. Industry practice is that health information is not used to cancel or nonrenew after issuance.

Rates – Loss ratios for groups are rated for the group and may vary depending on the product. Specified disease group insurance shall generate at least a seventy-five percent loss ratio. Group disability insurance, other than specified disease insurance, as to which the insureds pay all or substantially all of the premium must meet the loss ratios in the following table in WAC 284-60-060:

Number of Certificate Holders at Issue, Renewal or Rerating	Minimum Overall Loss Ratio
9 or less	60%
10 to 24	65%
25 to 49	70%
50 to 99	75%
100 or more	80%

C. Long-term care (LTC)

Issuance - Insurers will underwrite based on health information. This could include genetic information.

Renewal or cancellation - LTC policies are guaranteed renewable. An insurer can discharge its obligation to renew by obtaining for the insured coverage with another insurer which coverage provides equivalent benefits for value paid. WAC 284-54-100.

Rates - Similar policy forms should be grouped for rate-making because they are expected to have substantially like insuring, risk and exposure factors and expense elements. Grouping will enhance statistical reliability and improve the likelihood of premium adequacy without introducing elements of discrimination. It is unfair to withdraw a form from its assigned grouping by reason only of the deteriorating health of the insured persons. Individual rates are deemed reasonable in relation to the premiums if the overall loss ratio is at least sixty percent. WACs 284-54-620, 284-54-630 and 284-60-040.

Preexisting conditions - A LTC policy cannot exclude or limit coverage for preexisting conditions that received medical advice or treatment more than one year prior to coverage or more than six months after the effective date of coverage. RCW 48.84.040. If a LTC contract or certificate replaces another LTC contract or certificate, the replacing insurer shall waive any preexisting conditions waiting period to the extent that similar exclusions have been satisfied under the original contract. WAC 284-54-200.

D. Medicare Supplement (AKA "Medigap" or "Medsupp")

Issuance - Coverage cannot be denied or contingent on health status, claims experience, receipt of health care, or medical condition of an applicant. The application must be submitted prior to or during the six-month period after the first day of the first month that the individual is sixty-five years of age or older and is enrolled for benefits under Medicare Part B. WAC 284-66-077.

Renewal or cancellation - All medicare supplement policies are guaranteed renewable. The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation. RCW 48.66.090. Enrollees may be able to replace coverage without evidence of insurability. RCW 48.66.045.

Preexisting condition - A medicare supplement policy shall not exclude or limit benefits for losses incurred more than three months from the effective date of coverage because it involved a preexisting condition. A preexisting condition is a condition for which medical advice was given or treatment was recommended by or received from a physician, or other health care provider acting within the scope of his or her license, within three months prior to coverage.

Rates - Rates cannot discriminate based on health status, claims experience, receipt of health care, or medical condition of an applicant. The application must be submitted prior to or during the six-month period after the first day of the first month that the individual is sixty-five years of age or older and is enrolled for benefits under Medicare Part B. WAC 284-66-077.

III. Life Insurance

General rule – Health information, including genetic information can be used to deny a policy to an applicant. The information can be used in the initial rates offered to the consumer. A policyholder can't be cancelled after issuance based on later health conditions.

A. Individual coverage

Issuance – Insurer will ask for health information and may require a health exam. Issuance of a policy may depend on the results.

Renewal or cancellation – After issuance, insurer cannot cancel based on health.

Rates – The health information will be used to classify the risk into a category. Insurer will base the offered rates on that information. Premiums are set by contract. In term,

premiums may be fixed for all or part of the term, cannot be re-rated except where policy allows as a class. WAC 284-84-100.

> **Example***:* A 20-year term policy may be offered at a fixed rate for twenty years. After that time, a different rate may be offered.

B. Group coverage

Issuance – Insurers can require "a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his coverage." RCW 48.24.140.

Renewal or cancellation – If the individual loses eligibility because they lose their job or membership in the class eligible for coverage, the individual shall be entitled to have issued to him by the insurer, without evidence of insurability, an individual policy. RCW 48.24.180.

Rates – The group will be rated. A group life insurance contract may provide for a readjustment of the premium rate based on experience under that contract. RCW 48.24.240.

IV. Property/casualty

General rule – After review, we are unaware of the use of any health information, including genetic information, to deny, cancel or rate a policy. It does not seem to be specifically prohibited (except for possible grounds of discrimination). Health information, including genetic information, does not seem to be relevant to the product. An insurer using health information in denying an application, cancelling coverage, or charging different rates would have to justify that action.

V. Privacy Issues

Patient's Bill of Rights and Chapter 70.02 RCW - After the adoption of E2SSB 6199 (the "Patient's Bill of Rights") in 2000, insurers are held to the same standards as providers under Chapter 70.02 RCW. Generally, any disclosure would have to be authorized by the patient. There are exceptions to the general rule in RCW 70.02.050. Penalties for violation include a private party suit for actual damages.

Chapter 284-04 WAC - Additional safeguards are in Chapter 284-04 WAC requiring insurers to have policies and procedures, notices regarding the collection, use, protection, and destruction of health records. WAC 284-04-515 requires authorizations to include the type of information to be disclosed, the party or parties to whom the information will

be disclosed, the purpose or use of the disclosure, the duration of the authorization (24 month maximum), and the signature of the insured. WAC 284-04-065 prohibits discrimination against an insured for not authorizing disclosure. Penalties can range from the Insurance Commissioner levying a fine or suspending or revoking licensure to a private party Consumer Protection Act suit for treble damages up to $10,000.

Health Insurance Portability and Accountability Act (HIPAA) – HIPAA will provide a privacy "floor" for health insurers. It does not apply to any other line of insurance. Chapter 70.02 and Chapter 284-04 utilize many "HIPPA-like" features such as authorizations, procedures for collection, use, and destruction of information. Penalties vary if the violation is inadvertent or intentional. Civil money penalties are $100 per violation, up to $25,000 per person, per year for each requirement or prohibition violated. Congress also established criminal penalties for knowingly violating patient privacy. Criminal penalties are up to $50,000 and one year in prison for obtaining or disclosing protected health information; up to $100,000 and up to five years in prison for obtaining protected health information under "false pretenses"; and up to $250,000 and up to 10 years in prison for obtaining or disclosing protected health information with the intent to sell, transfer or use it for commercial advantage, personal gain or malicious harm. The HIPAA privacy rules become effective in 2003.

VI. Discrimination

Unfair discrimination in terms, conditions, benefits, or premiums of a contract is prohibited when insureds have "substantially like insuring, risk, and exposure factors, and expense elements." RCW 48.18.480. The Commissioner has the authority to adopt unfair practice rules and rules prohibiting unfair discrimination. RCW 48.30.010.

"Fair discrimination" is not prohibited. This can mean different rates, terms, or whether or not a policy is issued. "This provision shall not prohibit fair discrimination by a life insurer as between individuals having unequal expectation of life." RCW 48.18.480. This section "shall not prohibit fair discrimination on the basis of sex, or marital status, or the presence of any sensory, mental, or physical handicap when bona fide statistical differences in risk or exposure have been substantiated." RCW 48.30.300

VII. Other states and the National Association of Insurance Commissioners (NAIC)

The NAIC began to study aspects of the use of genetic information by insurers in the mid-1990s. A report was issued at that time. There is ongoing funding of a study regarding the use of genetic information in insurance. At this point no model regulation or law has been adopted.

Forty-two states have some provision addressing insurance coverage and genetic discrimination. The great majority of the provisions apply to health coverage. The regulations range from not allowing genetic testing of applicants for group health coverage to only permitting actuarially justified application of genetic information in rate making. A table summarizing those laws is also provided.